

OBSTETRICS

CLOSED CLAIMS STUDY



As the nation's largest physician-owned medical malpractice insurer, The Doctors Company has an unparalleled understanding of liability claims against obstetric professionals. Our data-driven approach enables us to anticipate emerging trends and deliver innovative patient safety tools to help our members reduce risk. And when a member's reputation and livelihood are attacked, insights gained from these studies help us provide the most aggressive defense in the industry.

To learn more about events that place obstetric professionals at risk, we reviewed 882 obstetrical claims that closed from 2007–2014. The results presented here reveal underlying vulnerabilities in the practice of obstetrics.

OBSTETRICS CLOSED CLAIMS STUDY FINDINGS

MOST COMMON PATIENT ALLEGATIONS

Obstetricians have the unique challenge of caring for two patients at the same time. Mothers and neonates have separate needs and can suffer different injuries. This study reviewed both maternal and neonatal claims for injuries suffered during pregnancy and the delivery process. Here are the three most common allegations:

1. Delay in treatment of fetal distress (22 percent). Although the term *fetal distress* should no longer be used clinically, it remains a common allegation in malpractice claims. A study of this subset of cases revealed that the most common cause of delayed treatment was physician failure to act when presented with Category II or III fetal heart rate (FHR) tracings predictive of metabolic acidemia.

In some cases, the physician waited to see if the neonate's FHR would improve. Some physicians did not agree with the nurse's assessment but did not assess the patient themselves. Others hesitated to initiate interventions like emergency cesarean sections when the cause of distress was not known in a premature fetus.

In some cases, the physician attempted an operative vaginal delivery without making a backup plan for an emergency cesarean section. When this approach was unsuccessful, the physician *then* ordered a stat cesarean section—which delayed the intervention.

2. Improper performance of vaginal delivery (20 percent). Almost half of these cases were brachial plexus injuries due to shoulder dystocia. Complaints were directed at inadequate maneuvers to deliver the shoulder. A significant number of these cases involved vacuum extraction or forceps deliveries where the patient failed to progress or the mother was obese. Neonates also suffered skull fractures and hematomas from high forceps deliveries. Maternal injuries included pelvic lacerations, tears, and fistulas.

3. Improper management of pregnancy (17 percent). These cases included failure to test for fetal abnormalities when indicated, failure to recognize complications of pregnancy, and failure to address

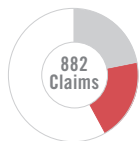
abnormal findings. Outcomes included intrauterine death, placental abruption, neonatal infections, neonatal brain injury, twin-to-twin transfusion, and maternal preeclampsia that led to stroke.

Other allegations: The top three allegations account for 59 percent of claims. Other allegations included diagnosis-related claims, delay in delivery, improper performance of operative delivery, retained foreign bodies, and improper choice of delivery method.

THREE MOST COMMON PATIENT ALLEGATIONS IN OBSTETRICAL CLAIMS



22% DELAY IN TREATMENT OF
FETAL DISTRESS



20% IMPROPER PERFORMANCE
OF VAGINAL DELIVERY



17% IMPROPER MANAGEMENT
OF PREGNANCY

FACTORS CONTRIBUTING TO PATIENT INJURY

Our expert physician and nurse reviewers identified specific factors contributing to patient injury. Here are their findings:

1. Selection and management of therapy (34 percent)

Issues included: decisions regarding labor and delivery, such as augmentation of labor, methods of delivery, and timing of interventions. Patients with past-due delivery dates and large babies were not assessed to determine the safety and likely success of a vaginal delivery. Patients with a history of shoulder dystocia were not evaluated or counseled regarding the risks of a reoccurrence and other delivery options. Oxytocin was continued or increased in cases where neonates had FHR patterns predictive of metabolic acidemia. Neonatal injuries resulted from excessive vacuum pop-offs in delivery.

Physician reviewers found management problems similar to those identified by patients. Their issues included failure to address pregnancy-induced hypertension, management of monochorionic twin pregnancies, failure to diagnose placenta percreta, inadequate diabetic management, failure to conduct genetic tests when indicated by parents' medical history, and failure to diagnose and treat preeclampsia.

Selection and management of therapy also applied to medications. Physicians failed to order antibiotics when pregnant patients were positive for Group A and Group B Strep. They also failed to order RhoGAM for Rh-negative mothers, magnesium sulfate for eclampsia, heparin for protein S deficiencies, and antibiotics for bacterial pneumonia.

Patient assessments are also fundamental to appropriate selection and management of therapy in pregnancy and labor.

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TOP SEVEN FACTORS CONTRIBUTING TO PATIENT INJURY



34% SELECTION AND MANAGEMENT OF THERAPY

- Management of pregnancy.
- Care during labor and delivery.
- Failure to order medication.



32% PATIENT ASSESSMENT ISSUES

- Failure to consider clinical information about mother and neonate.
- Failure to order diagnostic tests.
- Misinterpretation of FHR strips and diagnostic test results.



18% TECHNICAL PERFORMANCE

- Injury was a known risk.
- Poor technique in shoulder dystocia and operative vaginal delivery cases.



17% COMMUNICATION AMONG PROVIDERS

- Failure to communicate.
- Failure to review the medical record.
- Poor professional relationships/rapport.



16% PATIENT FACTORS

- Nonadherence with treatment plan.
- Nonadherence with follow-up calls or appointments.
- Nonadherence with medications.



14% INSUFFICIENT OR LACK OF DOCUMENTATION

- Clinical findings.
- Review of care.
- Clinical rationale for decisions.



14% COMMUNICATION BETWEEN PATIENT/FAMILY AND PROVIDER

- Inadequate informed consent for other treatment options.
- Poor rapport.
- Insufficient follow-up instructions.

Note: Some claims had more than one contributing factor.

FACTORS CONTRIBUTING TO PATIENT INJURY

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2. Patient assessment issues (32 percent). Physicians disregarded available information (test results or documented findings in the medical record) and failed to order diagnostic tests for Strep infections, elevated blood sugar, and hypertension. They also ignored abnormal findings, such as the size of neonates, signs of preeclampsia, glycosuria, and elevated urine protein.

Analysis showed that key pieces of information were overlooked. Examples of missing information included failure to recognize symptoms of placental abruption or retroperitoneal hemorrhage, fetal monitor strips as being indicative of metabolic acidemia, macrosomia, and infectious processes in mother or fetus. Also a factor: misinterpretation of genetic testing reports as being negative for Down syndrome or neural tube defects.

3. Technical performance (18 percent). Examples included injuries related to known risks disclosed to the patient prior to the procedure, such as postpartum hemorrhage, brachial plexus injuries, and punctures or lacerations. It also included poor technique.

4. Communication among providers (17 percent). Failure to keep other providers updated on a patient's condition may have been due to poor professional relationships and poor rapport. Communication breakdown also occurred when physicians failed to review the medical record or nurses failed to timely notify physicians of a change in a patient's condition.

5. Patient factors (16 percent). Issues that affected the outcome of care included patients who did not comply with treatment plans or conditions, such as diabetes and preeclampsia. It also included lack of adherence to scheduled appointments or prescribed medications.

6. Insufficient or lack of documentation (14 percent).

Documentation deficiencies included clinical findings, review of care, clinical rationale for decisions, informed consent discussions, and documentation of adverse events.

7. Communication between patient/family and provider (14 percent). This factor may be associated with patient compliance. Issues identified included inadequate follow-up instructions, problems due to poor rapport between physicians and patients, and language barriers. Lack of informed consent for all treatment options was also identified as a communication problem.

OBSERVATIONS

Studying obstetrical medical malpractice claims sheds light on the wide array of problems that may arise during pregnancy and in labor and delivery. Many of these cases reflect unusual maternal or neonatal conditions that can be diagnosed only with vigilance. Examples include protein deficiencies, clotting abnormalities, placental abruptions, infections, and genetic abnormalities. More common conditions should be identified with close attention to vital signs, laboratory studies, changes to maternal and neonatal conditions, and patient complaints.

Obstetric departments must plan for clinical emergencies by developing and maintaining physician and staff competencies through mock drills and simulations that reduce the likelihood of injuries to mothers and their infants.

By Darrell Ranum, JD, CPHRM, Vice President, Department of Patient Safety and Risk Management

By David B. Troxel, MD, Medical Director, Board of Governors

LEARN MORE

For more information on how we're helping obstetric professionals enhance patient safety and avoid claims, call (800) 421-2368, or visit www.thedoctors.com/patientsafety.



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